Gynaecology Billing Services: What GYN Practices Need Most From Their Billing Partner

Gynaecology billing often appears simple from the outside. Most people think of routine office visits, preventive exams, and minor procedures. On the surface, it seems like a straightforward specialty to bill.

In reality, gynaecology billing is far more complex.

GYN practices deal with a unique mix of evaluation and management services, preventive care visits, office-based procedures, surgical interventions, and, in many cases, billing considerations that overlap with obstetrics. On top of that, payers apply highly specific rules to women's health services, making accurate billing and coding essential for proper reimbursement.

The challenges often come down to details. Modifier requirements can be complex. The difference between a preventive visit and a diagnostic visit can significantly impact reimbursement. Procedures such as colposcopies, hysteroscopies, endometrial biopsies, and other gynaecologic surgeries require specialty-specific coding knowledge that many general billing teams simply do not have.

Because of this complexity, revenue loss in gynaecology practices is often difficult to spot. It may not show up as a large volume of denied claims. Instead, it appears through undercoded procedures, missed billable services, incorrect preventive versus diagnostic visit classification, and coding or modifier errors that reduce reimbursement without triggering an obvious denial.

Over time, these small mistakes can add up to a significant loss in revenue.

This is why choosing the right gynaecology billing partner matters. A billing team with specialty-specific expertise can identify opportunities that generalist billing operations frequently overlook while helping the practice maintain compliance and maximize reimbursement.

In this blog, we'll look at what gynaecology practices should expect from their billing partner, the most common billing challenges in women's healthcare, and the areas where general medical billing teams often fall short.

See how specialty billing gaps are affecting practices across medicine — Read More here.

Gynaecological Procedure Coding: Where Revenue Often Gets Missed

Gynaecology practices perform a wide range of procedures, from simple office-based treatments to more complex surgical interventions. While these services may seem routine, accurate coding is critical because even small mistakes can affect reimbursement and compliance.

Colposcopy Coding

Colposcopy procedures require careful code selection. CPT codes 57452 through 57461 vary depending on what was performed during the procedure, including whether a biopsy was taken, an endocervical curettage (ECC) was completed, or a loop excision procedure was performed.

A common issue occurs when a lower-level colposcopy code is billed even though additional services, such as a biopsy and ECC, were completed during the same visit. Over time, this can lead to significant underbilling.

To support accurate coding and reimbursement, documentation should clearly identify every component of the procedure.

Hysteroscopy Coding

Hysteroscopy coding can also be challenging because the procedures range from simple diagnostic evaluations to more advanced operative interventions.

Diagnostic hysteroscopy (58555) is billed differently from operative hysteroscopy procedures (58558–58565), which may include services such as endometrial ablation, myomectomy, or septum resection.

Each procedure represents a different level of clinical work and reimbursement. The operative report should clearly describe exactly what was performed so the correct code can be assigned. When multiple procedures are completed during the same hysteroscopy, proper code selection and modifier usage become even more important and often require specialty-specific coding expertise.

Endometrial Biopsy

Endometrial biopsy (CPT 58100) is one of the most commonly performed gynaecological office procedures and one of the most frequently underbilled.

This procedure is separately billable from the office visit in which it is performed. However, many practices unintentionally bundle it into the E/M service and lose reimbursement they are entitled to receive.

On the other hand, billing the procedure separately without the appropriate modifier can cause the office visit to be bundled and denied. Accurate coding and modifier use are essential to ensure both services are reimbursed correctly.

IUD Insertion and Removal

IUD insertion (58300) and IUD removal (58301) are separately billable procedures.

When these services are performed during an office visit, the E/M service may also be billed separately with modifier 25 when documentation supports a significant and separately identifiable evaluation and management service.

In many cases, the device itself may also be separately billable, depending on the payer and how the practice purchases and supplies the IUD.

Successful reimbursement depends on correctly billing all applicable components, including the procedure, the office visit, and the device when appropriate.

Pap Smears and Cervical Cytology

Pap smear and cervical cancer screening services involve multiple billing components that are often misunderstood.

Liquid-based cytology collection (88142–88143) and conventional Pap smear services (88150) have their own billing codes that are separate from the collection fee included in a preventive visit. When HPV co-testing is performed, additional billable services may apply.

Because these services involve multiple codes and payer-specific rules, they are a common source of bundling issues, missed charges, and underbilling. Understanding how preventive visits, collection fees, cytology services, and laboratory testing interact is essential for accurate reimbursement.

The Global Period Issue in Gynaecological Surgery

One area that often creates billing confusion in gynaecology is the surgical global period.

When a gynaecological procedure includes a global surgical period, follow-up care related to that procedure is generally included in the surgical payment and cannot be billed separately. In other words, the surgeon is expected to manage the patient's routine recovery without additional reimbursement during that timeframe.

For most major gynaecological surgeries, the global period is typically 90 days. Minor procedures may carry a 0-day or 10-day global period, depending on the specific service performed.

Problems arise when practices either bill for postoperative visits that are already included in the global package or fail to bill for visits that are actually unrelated and separately reimbursable.

For example, a routine postoperative follow-up visit during the global period is usually bundled into the surgical payment. Submitting a separate claim for that visit often results in a denial. On the other hand, if a patient presents during the global period for a completely unrelated medical issue, that visit may still be billable when the appropriate modifier is applied.

This is where many gynaecology practices lose revenue or create unnecessary compliance risks. Some practices unintentionally bill bundled postoperative visits and face denials. Others avoid billing altogether during the global period, even when they are entitled to reimbursement for unrelated services. Understanding the difference between related and unrelated care is essential to ensuring accurate billing and proper payment.

Preventive Screening Services and Their Billing Nuances

Preventive care is a major part of gynaecology, but it also comes with some of the most complex billing rules.

Services such as mammography referrals, bone density screening, STI testing, contraception counselling, and cancer risk assessments all have unique coding and coverage requirements. Small documentation errors can easily lead to denials, underpayments, or missed reimbursement opportunities.

Take BRCA counselling and genetic testing as an example. Coverage often depends on the patient's risk factors, family history, and medical necessity documentation. Without proper supporting documentation, claims may be denied or flagged for review.

Cervical cancer screening follow-up is another common area of confusion. A routine Pap smear may be billed as a preventive service, but when a patient requires a colposcopy following an abnormal result, the service typically shifts from preventive care to diagnostic care. Billing the follow-up correctly is important because preventive and diagnostic services are often reimbursed differently by payers.

Contraception counselling and management also involve multiple billing components. Depending on the service provided, practices may bill evaluation and management services, procedure codes, device charges, or a combination of all three. Long-acting reversible contraceptives such as IUDs and contraceptive implants add another layer of complexity because the device, insertion procedure, and counselling services may all have separate billing requirements.

Because payer policies vary significantly, accurate coding and documentation are critical to ensuring gynaecology practices receive appropriate reimbursement for the preventive services they provide every day.

What Generalist Billing Teams Often Miss

The Preventive vs. Diagnostic Visit Distinction

One of the most common billing challenges in gynaecology is correctly identifying whether a visit should be billed as preventive or diagnostic.

A routine well-woman exam can quickly become a diagnostic visit if the patient presents with symptoms, concerns, or abnormal findings that require additional evaluation. The coding requirements and payer coverage rules can change significantly based on that distinction.

Accurate billing requires careful review of the clinical documentation at every encounter. Applying the same coding approach to every annual visit can lead to underpayments, claim denials, or missed reimbursement opportunities.

Procedure Coding During Complex Encounters

Many gynaecological procedures involve multiple components that may be separately reportable when supported by documentation.

For example, a hysteroscopy or colposcopy may include additional services such as biopsies, endocervical curettage, or other procedural elements. When billing teams default to a single base code without reviewing the full operative note, complex procedures are often undercoded.

Specialty-focused billing teams understand how to identify and capture all billable components while maintaining coding compliance.

Modifier 25 and Modifier 57 Usage

Modifier selection is another area where errors frequently occur.

When an evaluation and management (E/M) service is performed on the same day as a procedure, the correct modifier must be applied to ensure appropriate reimbursement. Depending on the procedure and the circumstances of the visit, this may involve Modifier 25 or Modifier 57.

The challenge is that the rules are not always straightforward. In addition to Medicare guidelines, many commercial payers apply their own policies and edits. Knowing when and

how to use these modifiers correctly requires specialty-specific billing knowledge and payer awareness.

Managing Global Surgical Periods

Tracking global periods is essential in gynaecology billing.

Billing teams need to know which patients are currently within a global period, which follow-up services are already included in the surgical payment, and which visits may still qualify for separate reimbursement because they are unrelated to the original procedure.

Without a structured process for monitoring global periods, practices often experience unnecessary denials or miss legitimate billing opportunities.

Payer-Specific Women's Health Coverage Rules

Women's health services are subject to a wide range of payer-specific policies.

Coverage requirements for preventive gynaecological services, contraception management, BRCA counselling and testing, and other women's health procedures can vary significantly between commercial insurers, Medicare, and Medicaid plans. These policies also change frequently.

A billing team that applies the same rules across all payers is likely to encounter avoidable denials and reimbursement issues. Successful gynaecology billing requires staying current with payer-specific requirements and adjusting billing workflows accordingly.

The Takeaway

Gynaecology billing may not seem as complex as specialties like interventional cardiology or neurosurgery, but that does not make it simple. It comes with its own set of challenges, including preventive versus diagnostic coding, procedure-specific billing requirements, global period management, and payer-specific rules for women's health services.

These are the areas where generalist billing teams often struggle. The impact is not always obvious. Instead of generating large volumes of denials, these mistakes often show up as undercoded procedures, missed billable services, or incorrectly applied modifiers that quietly reduce reimbursement over time.

A billing partner with dedicated gynaecology expertise understands these nuances and knows how to capture every service accurately. That means fewer billing mistakes, stronger compliance, and more revenue being collected for the care your practice is already providing.

GoSourceMD provides specialized gynaecology billing services designed to help GYN practices maximize reimbursement, reduce billing errors, and stay compliant with constantly changing payer requirements.

FAQs

Q. When can I bill both a preventive visit and an office visit on the same day?

In certain situations, both services can be billed during the same encounter. If the provider performs a significant and separately identifiable evaluation and management (E/M) service in addition to the preventive exam, the office visit may be billed separately using Modifier 25.

The additional E/M service must address a new or existing medical problem that goes beyond the scope of the routine preventive visit. Clear documentation is essential and should distinguish the preventive exam from the problem-focused evaluation performed during the same appointment.

Q. What is the global period for common gynaecological procedures?

The global period varies depending on the procedure.

Major gynaecological surgeries, such as hysterectomies, myomectomies, and many major laparoscopic procedures, generally carry a 90-day global period. Minor procedures, including endometrial biopsies, IUD insertions, and certain colposcopy services, typically have a 0-day or 10-day global period.

Because global periods can vary by procedure and payer, practices should always verify the specific CPT code in the Medicare Physician Fee Schedule and review any payer-specific guidelines that may apply.

Q. Can I bill separately for an IUD device and the insertion procedure?

In many cases, yes. When a practice purchases and supplies the IUD directly, the device and the insertion procedure are often billed separately using the appropriate HCPCS and CPT codes.

However, coverage rules vary by payer and health plan. Some insurers cover the device through medical benefits, while others process it through pharmacy benefits. Verifying payer-specific requirements before billing can help avoid denials and reimbursement delays.

Q. How should I bill when a patient has both commercial insurance and Medicaid?

The commercial insurance plan should be billed first as the primary payer.

Once the primary claim has been processed, apply the payment and any contractual adjustments. If there is a remaining balance that qualifies for secondary billing, submit the claim to Medicaid. In most states, Medicaid serves as the payer of last resort and may cover eligible remaining amounts up to the Medicaid allowable rate.

Practices should not bill the patient for balances that are covered by Medicaid under applicable state and federal guidelines.